As part of the legislation passed last session to create the new Department of Health and Human Services (DHHS), the Bureau of Health was renamed the Maine Center for Disease Control and Prevention (Maine CDC). The federal Centers for Disease Control and Prevention will be referenced as "CDC".

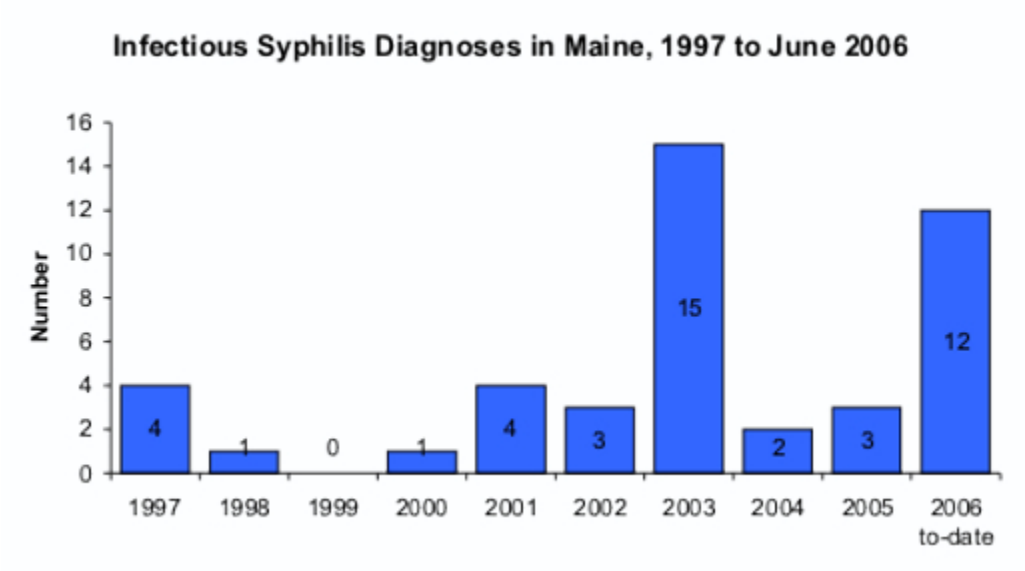
Dora Anne Mills, MD, MPH: Maine Public Health Director; State Health Officer; Director, Maine CDC	Sally-Lou Patterson: Director, Division of Infectious Disease	Kathleen F. Gensheimer, MD, MPH: State Epidemiologist; Editor, Maine Epi-Gram

August 2006 Issue Contents

Be on the Lookout: 2006 Syphilis Increase in Maine

Since January 1, 2006, health care providers in Maine have diagnosed 12 cases of *early syphilis* (infected within one year) among nine males and three females, ages 17-48 (median: 34 years old), in Cumberland, Kennebec, Waldo, Oxford and Somerset Counties. Three cases were primary syphilis, four cases were secondary syphilis and five cases were early latent syphilis. Three of the cases were among males with HIV infection and six were among those whom identified as MSM (men who have sex with men).

These numbers represent an increase compared to the same period in 2005, when there was one case reported. During the last ten years, the annual average number of reported syphilis cases is two, except for 2003 when Maine experienced a syphilis outbreak of 15 cases. Because syphilis is rarely reported in Maine, the twelve reported cases so far this year are cause for concern.



In order to ensure appropriate diagnosis and treatment of cases and to prevent further transmission, the Maine Center for Disease Control & Prevention recommends:

- Clinicians consider syphilis during evaluations for possible STD. Syphilis has many signs and symptoms that are indistinguishable from those of other diseases. Syphilis is passed most commonly in the infectious primary stage from person to person through direct contact with a primary syphilis sore. The secondary stage of the disease can also be highly infectious.

- Clinicians are aware of the primary stage of syphilis and its symptoms. The primary stage begins at the original site of infection 10 days to 90 days (average of 21 days) after inoculation. Primary syphilis is usually marked by the appearance of a single sore (chancre), but there may be multiple sores. The primary sore is usually an eroded papule that is firm, the surface may be

crusted or ulcerated, the border surrounding the lesion is frequently raised and firm. The sore is most often painless. Lymph nodes draining the involved area are frequently enlarged and hard. Primary lesions are not confined to, but most often in the vagina, rectum, or mouth.

- Clinicians note that between the primary and secondary stages of syphilis most often a latent stage occurs. During this latent stage no observable clinical signs and symptoms are present to suggest infection. The *early* latent stage of syphilis is defined as latent disease within the first year of infection. These periods can occur between the primary and secondary stages, between secondary relapses, and after the secondary stage. There can be 0-10 weeks (average 4 weeks) of latent syphilis between the disappearance of the primary lesion and the onset of secondary symptoms.

- Clinicians be aware that secondary syphilis symptoms include alopecia, skin and mucous membrane lesions (lesions are bilaterally symmetrical). More specifically, moist papules (condylomata lata) in anogential region or mouth, lesions of the mouth, throat and cervix (mucous patches), palmer/planter rash (macular or papular), and nickel/dime lesions (typically on the face) are the most common signs of secondary syphilis.

- Clinicians ensure that diagnostic specimens for syphilis are obtained during screening. Screening usually consists of a Rapid Plasma Reagin (RPR) test. Reactive specimens should be confirmed through additional testing such as a Treponema Pallidum Particle Agglutination (TP-PA) or a Fluorescent Treponemal Antibody- Absorption (FTA-ABS).

- Clinicians refer all confirmed syphilis cases to the Maine Center for Disease Control & Prevention for disease intervention activities, to include partner elicitation and testing at 287-3747, or 800-821-5821.

- Clinicians follow the most recent CDC recommendations for syphilis evaluation and treatment, available at http://www.cdc.gov/std/default.htm.

Contributed by Jennah Godo

Cholera and Other *Vibrio* Illnesses: Summary of 2004-05 Surveillance - Maine and United States

There are two major categories of *Vibrio* species: *V. cholerae* isolates that produce cholera toxin (referred to as toxigenic *Vibrio cholerae* and very rare in the United States), and all other *Vibrio* isolates such as *V. haemolyticus, V. algonilyticus* and those *V. cholerae* isolates that do not produce cholera toxin.

Since 1988, the federal CDC has maintained a database of reported infection with any species of *Vibrio* from humans in order to obtain reliable information on illnesses associated with the range of *Vibrio* species. This reporting system was

initiated by the Food and Drug Administration (FDA), the federal CDC and the Gulf Coast states, but has since been adopted by many other states, including Maine. Participating states collect clinical data, identify history of seafood consumption and exposure to seawater in the seven days before illness, and conduct tracebacks of implicated oysters. In Maine, the Infectious Disease Epidemiology Program of the Maine CDC works in collaboration with the Department of Marine Resources and State Health and Environmental Testing Laboratory (HETL) to conduct relevant investigations of all reported cases of *Vibrio*.

This article summarizes data from 2004 national Vibrio surveillance with highlights of confirmed cases reported in Maine from 2004 to 2005. Results are presented in two categories: toxigenic *Vibrio cholerae*, and all other *Vibrio* isolates.

Isolates of toxigenic *Vibrio cholerae*

No cases of toxigenic *V. cholerae* were reported in Maine in 2004. Nationally, a total of eight patients were identified. Four patients acquired the infection while traveling in Asia, and one from travel to Hawaii. Two patients were Georgia residents: one consumed oysters, later traced back to Florida, three days before onset of his symptoms and the other Georgia resident reported no known exposure to seafood in the 10 days preceding illness. The last of the eight patients was an Alabama resident who consumed oysters 10 days before onset of his symptoms. The oysters could not be traced back to their harvest site. Overall, three patients were hospitalized and one died.

Other *Vibrio* isolates (including non-toxigenic *V. cholerae*)

Maine

In 2004, four *Vibrio* cases were reported to the Maine CDC. *V. parahaemolyticus,* the primary species seen in Maine, was isolated from three cases while *V. alginolyticus* was isolated from one case. Of the three *parahaemolyticus* cases, one was a fisherman with no known history of eating raw seafood in the seven days prior to illness but reported eating cooked clams and was routinely exposed to drippings from raw seafood; the second case was immune compromised with no travel history and no known seafood exposures; the third *parahaemolyticus* case became sick after consuming raw oysters. The single case of *alginolyticus* was a fisherman who had a pre-existing wound with repeated exposure to seawater and contact with raw seafood.

In 2005, the Maine CDC received reports of two *Vibrio* cases. The first case was infected with *V. parahaemolyticus* and reported consumption of cooked shrimp, crab, and haddock. The individual also reported contact with a household member who had diarrheal symptoms during the exposure period. The second case, a victim of *V. alginolyticus*, reported travel to the British Virgin Islands in the seven days prior to illness and sustained a wound while swimming in the ocean waters around the islands.

Overall, six *Vibrio* cases were reported to the Maine CDC during the period from 2004 to 2005. None of the cases were hospitalized. There were no known deaths associated with *Vibrio* infection. Four isolates were classified as *V. parahaemolyticus* and came from stool samples, while two isolates were classified as *V. alginolyticus* and came from wound sites. Five of the six cases occurred in the summer months, consistent with the annual seasonal peak nationwide.

United States

On the national level, 479(1) cases (contributing 501 isolates) were reported to the Cholera and Other *Vibrio* Illness Surveillance System in 2004. Among patients for whom information was available, 173 (38%) of 460 were hospitalized and 39 (9%) of 443 died. *V. parahaemolyticus* was isolated from 240 (51%) patients, and was the most frequently reported *Vibrio* species. *V. vulnificus,* the most virulent strain, was isolated from 92 (19%) patients; 88% were hospitalized and 39% died. The number of patients from whom *Vibrio* species was isolated had a seasonal peak during the summer months of July and August. Consistent with previous years, the major sources of exposure included consumption of cooked and raw seafood, wound-exposure, handling seafood, contact with marine wildlife, and travel to a foreign country during the 7 days prior to the onset of illness.

Among the *Vibrio* isolates from all states, more than half were from stool, and the others from blood, wounds, ear, gallbladder, urine, and other sites. *V. parahaemolyticus* was the species most frequently isolated from stool. *V. vulnificus* was the species most frequently isolated from blood and from wounds.

The information gathered from *Vibrio* surveillance and presented in this article can be used to educate the public about the health risks associated with eating contaminated, raw or improperly cooked seafood, contact with marine wildlife, and exposures to contaminated seawater. In Maine, surveillance data are also used to assist the Department of Marine Resources in their efforts to promote the safety of shellfish by reducing contamination and illegal harvesting of commercial shellfish.

(1)*In 2004, only toxigenic V. cholerae O1 and O139 were nationally notifiable, thus the true number of Vibrio isolates could be greater than reported. In April 2006, the federal CDC formally asked states to report all Vibrio species to the national database.*

Contributed by Kathleen Gensheimer and Anthony Yartel

Infectious Disease Epidemology Surveillance Report: Rabies

Background

The Infectious Disease Epidemiology program and the Maine Health and Environmental Testing laboratory of the Maine Center for Disease Control and Prevention monitor the incidence of animal rabies through mandatory reporting of suspected animal rabies by veterinarians, animal control officers, health care

providers and other health professionals. This report summarizes surveillance data on animal rabies and rabies post-exposure prophylaxis (PEP) from 2005.

Methods

Rabies is diagnosed in animals by direct fluorescent antibody testing, preferably performed on central nervous system tissue. Maine's Health and Environmental Testing Laboratory performs rabies testing on animals with human or domestic animal exposure, or animals without exposure at the submitter's cost. During 2005, laboratory personnel followed up all rabies-positive animals identified to provide recommendations to prevent spread of the virus. In addition, standardized case report forms were completed for reported human or domestic animal exposures with potentially-rabid animals in 2005, which gathered information on the index-animal's species, vaccination history and current health status, circumstances of the potential exposure, and public health actions taken to prevent spread of rabies, such as PEP .

Results

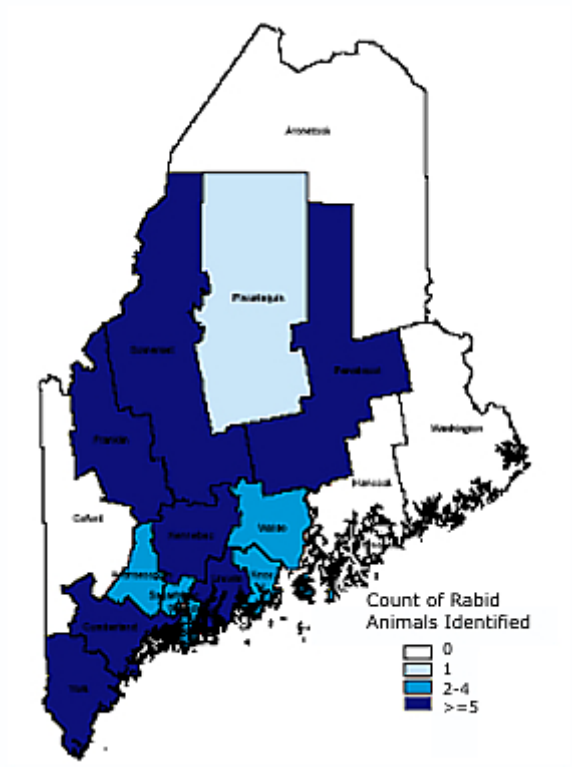
A total of 683 animals were submitted for rabies testing during 2005. Of these, 61 (8.9%) were positive for the rabies virus, including 3 bats (big brown), 37 raccoons, and 21 skunks (Table).
The number of animal rabies cases identified during 2005 was slightly lower than the median number of cases reported during the previous 5 years (median 82, range 67-139). No domestic animals were identified as rabies-positive during 2005, whereas at least one domestic rabid animal was identified during three of the previous five years.

Animals Submitted for Rabies Testing by Positive Result and Species – Maine, 2005

Species	Received	Positive	
	No.	No.	%
Alpaca	2	0	0
Bat	196	3	1.5
Beaver	2	0	0
Bobcat	2	0	0
Cat	176	0	0
Cattle	8	0	0
Chipmunk	2	0	0
Coyote	3	0	0
Deer	1	0	0
Dog	69	0	0
Donkey	2	0	0
Ferret	2	0	0
Fisher	1	0	0
Fox	11	0	0
Goat	2	0	0
Groundhog	19	0	0
Horse	2	0	0
Mink	2	0	0
Mouse	1	0	0
Muskrat	3	0	0
Porcupine	1	0	0
Rabbit	3	0	0
Raccoon	118	37	31.4
Rat	1	0	0
Sheep	1	0	0
Skunk	43	21	48.8
Squirrel	6	0	0
Weasel	2	0	0
Wolf/Hybrid	3	0	0
Total	**683**	**61**	**8.9**

Rabies-positive animals were identified in 48 towns in 12 of Maine's 16 counties in 2005. The statewide distribution of positive animals may not be representative of rabies in the state and only represents animals submitted for testing. The majority of specimens submitted were due to interaction between the animal tested and a human or domestic animal.

Animal Rabies by County - Maine 2005



Rabies Post Exposure Prophylaxis

During 2005, the Infectious Disease Epidemiology program received a total of 54 consultations regarding rabies post-exposure prophylaxis. Of these, 12 (22%) potential exposures warranting PEP were ruled out by a negative laboratory test. An additional 12 (22%) consultations involved domestic cats, dogs and ferret bites where a 10-day quarantine was recommended to determine if PEP was indicated. The majority (n=25, 46%) of consultations involved a potential exposure where no animal was available for testing or observation. Five (9%) consultations involved animals confirmed as rabies-positive.

Of the 54 consultations, 26 (50%) case-patients were recommended to receive rabies PEP. The majority of PEP patients were female (54%), and the age distribution ranged from 5 months to 61 years of age with a median age of 25 years. Exposure incidents associated with PEP included contact with bats (65%), raccoons (27%), dogs (4%), minks (4%), skunks (4%), and wolf-hybrids (4%).

Discussion

Animal rabies is found regularly among wild animals and occasionally among unvaccinated domestic animals in Maine. Recognition, prompt assessment, and

management of potential rabies exposures will prevent human and domestic animal rabies in Maine.

The majority of patients receiving rabies PEP in 2005 may have avoided this invasive and expensive procedure had the animal suspected of rabies been captured and submitted for rabies testing. Informing members of the public about the risks of rabies when coming into contact with wild or unattended domestic animals may prevent future exposures. Municipal animal control officers, veterinarians, and health care providers greatly facilitate public education around rabies when assessing potential rabies exposures. Maintaining domestic animal vaccination status and avoiding animals that are unknown are effective methods of rabies prevention.

Suspect animal and human rabies is reportable immediately by telephone to our 24-hour disease reporting line 1-800-821-5821. Rabies PEP will be added as a reported condition when the notifiable disease rules change; until then, we request that public health partners report rabies PEP by calling the disease reporting line, or faxing reports to 287-8186. Epidemiologists are available to assess animal exposures, facilitate the testing of animals, and provide guidance on administering PEP.

For more information on animal rabies, see the Maine CDC rabies surveillance website (www.maine.gov/dhhs/boh/ddc/rabies_surveillance.htm) and the Maine Rabies Management Guidelines (2005) posted at (www.maine.gov/agriculture/ahi/Rabies%20Management%20Guide%202005.pdf).

Contributed by Anne Sites

Post-Exposure Prophylaxis After Pre-Exposure Prophylaxis?

Adapted from Epi Notes, Disease Prevention and Epidemiology Newsletter, South Carolina Department of Health and Environmental Control, Vol. XXV, No 5, 2006.

At the Maine CDC, we regularly field questions from providers concerning infectious diseases and public health recommendations for control measures Here, we address a common question relating to post-exposure prophylaxis of infectious disease entities.

Question from Medical Provider's Office: In our practice we recently saw a child from out-of-state who had been a household contact to a recently diagnosed case of hepatitis A. Since we had seen the child within 14 days following her exposure to the source case, she seemed to be a candidate to receive Immune Globulin (IG) as post-exposure prophylaxis. However, the child's vaccine record showed she had previously received hepatitis A vaccine. The question, therefore, was whether IG was still indicated in this situation.

Epidemiologist's Answer: Though this question relates to a particular situation involving hepatitis A, it also provides a good opportunity to consider the more general question about when, whether, and why pre-exposure prophylaxis (PrEP) [usually a vaccine] may, or may not, modify otherwise standard indications for post-exposure prophylaxis (PoEP). We will address this more general question through several hypothetical case scenarios:

Scenario 1 – Pertussis: Two siblings, a 20 month-old and a 2 month-old have been exposed to a case of pertussis. The 20 month-old has received four doses of DTP; the 2 month-old has yet to receive a single dose. Standard guidelines recommend that the children's immunization histories not be taken into account and that both children received identical courses of PoEP with an appropriate antibiotic.

Scenario 2 – Rabies: A forestry field worker has previously received PrEP rabies vaccine because of potential occupational risk. While walking in the woods, he is bitten by a raccoon, the raccoon tests positive for rabies. Although rabies PoEP normally calls for administration of Rabies Immune Globulin (RIG) and five doses of rabies vaccine administered over a 28-day period, recommendations for this previously vaccinated patient are that he need not receive RIG and needs to received only two doses of rabies vaccine, administered over a 4-day period.

Scenario 3 – Hepatitis A: This scenario is the one that described in the question addressed above. Here standard guidelines state that: "Persons who have been recently exposed to HAV and who have not previously been administered hepatitis A vaccine should be administered a single IM dose of IG (0.02 mL/kg) as soon as possible, but not >2 weeks after the last exposure. Persons who have been administered one dose of hepatitis A vaccine at least 1 month before exposure to HAV do not need IG".

Comment: These scenarios illustrate that the details and inter-relationships between PrEP and PoEP are complex and vary from one infectious disease to another. Thus, following PrEP and then an "exposure", PoEP may:

- remain necessary without modification of guidelines (e.g. pertussis)
- remain necessary, but with modified details (e.g. rabies)
- not be necessary and may be dispensed with altogether (hepatitis A)

Further, for some diseases, guidelines regarding PoEP are so complex, with the best course of action dependent on many variables, that recommendations cannot readily be presented in a single sentence or two; rather, they must be presented in a more structured format.

A familiar example is the recommendations summarizing the approach to tetanus PoEP where the need to administer Tetanus Immune Globulin (TIG) and/or a booster dose of Td depends on (a) the number of doses of TT/Td/DPT previously

received, (b) the number of years since the last dose was administered, and (c) the nature and extent of the wound.

Likewise, the approach for (Hepatitis B PoEP) after a needle stick is summarized in a complex table http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5011a1.htm#tab3 which takes into account the vaccination and antibody response status of the exposed person and what is known about the HBsAg status of the source.

In a few instances specific guidance on the relationship between PoEP and PrEP are lacking. For example, following the January 2005 licensure of the new tetravalent meningococcal polysaccharide-protein conjugate vaccine, the CDC published updated recommendations regarding the prevention and control of meningococcal disease. However, in the section devoted to antimicrobial chemoprophylaxis, no mention is made of whether or how standard recommendations for PoEP antibiotic chemoprophylaxis ought to be modified for persons who have received the vaccine.

Thus, pending future guidance, management of a teenager who had received the vaccine but was later found to be a close (e.g. household) contact to a case of meningococcal meningitits would have to depend on "expert opinion" rather than on published guidelines. Considering the severity of the disease, the ease and the safety of antibiotic prophylaxis, as well as the likelihood that the serotype of the organism would be unknown Maine CDC would recommend prophylaxis.

This last example notwithstanding, current versions of standard guidelines (such as those from the federal Centers for Disease Control and Prevention or the American Academy of Pediatrics) include considerably more detailed guidance than available within this article. And because questions regarding appropriate post exposure prophylaxis can be confusing, the epidemiology team within the Division of Infectious Disease, Maine CDC is available to provide consultation regarding issues of post-exposure prophylaxis for individuals or groups exposed to infectious diseases. Please remember that the disease entities for which you would be seeking consultation for prophylaxis are also reportable by law to the Maine CDC. Please call us at 800 821 5821 for consultation or for disease reporting.

Contributed by Kathleen Gensheimer

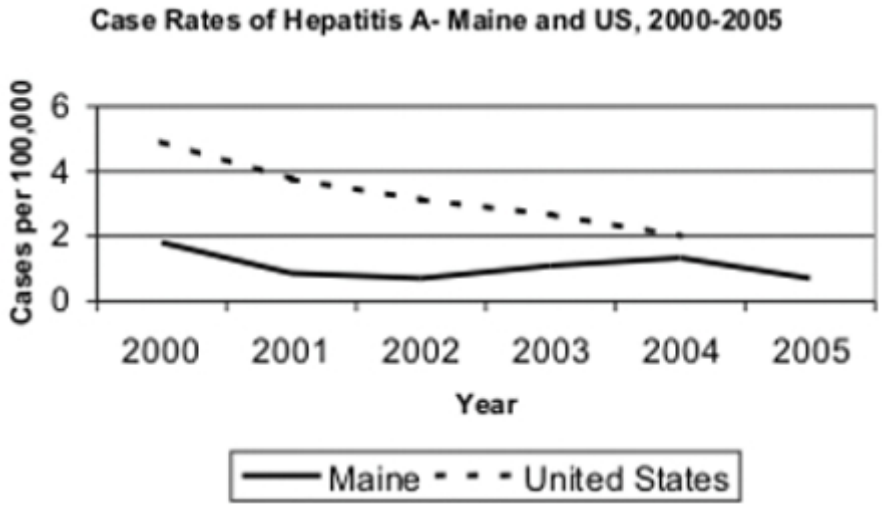
Updated ACIP Recommendations for Hepatitis A and Hepatitis B Vaccine

Adapted from *IAC Express* 3-27-06 and *Hep Express* #42 "Viral hepatitis news from the Immunization Action Coalition" found online at: www.immunize.org

In December 2005 and in May 2006, respectively, CDC published updates to recommendations for the administration of hepatitis A and B vaccine. Brief summaries of the changes are described in this article. For more detailed

information, please see web links to the original MMWRs at the bottom of this article.

In 2005, the Maine CDC reported 9 cases of hepatitis A and 14 cases of hepatitis B. The 5-year median of reported hepatitis A cases in Maine was 11 and 12 for hepatitis B. The hepatitis A case rate in 2005 for Maine was 0.7 per 100,000 while the national case rate (2004) was 1.9 per 100,000. Hepatitis B case rate for 2005 for Maine was 1.1 per 100,000 while the national rate in 2004 was 2.1 per 100,000.



While Maine continues to have lower rates than the U.S., the fact we have cases of vaccine preventable diseases suggests we have more work to do. To help in this effort, the new CDC recommendations are described below.

Hepatitis A

The major change for hepatitis A vaccine is the recommendation for routine vaccination of children nationwide for age one and older. Previously, hepatitis A vaccine was recommended for children age 2 and older in states, counties, and communities with consistently elevated rates of hepatitis A.

These updated recommendations represent the final step in the childhood hepatitis A immunization strategy. Implementation of these recommendations will reinforce existing vaccination programs, extend the benefits associated with hepatitis A vaccination to the rest of the country, and create the foundation for eventual consideration of elimination of indigenous hepatitis A virus transmission. In Maine, only children who qualify for the Vaccines for Children program will be eligible to receive the vaccine for free from the Maine CDC Immunization Program. All others will need to use private insurance or self-pay.

The May 2006 MMWR updates ACIP's 1999 recommendations concerning the prevention of hepatitis A through immunization (CDC. Prevention of hepatitis A through active or passive immunization: recommendations of the Advisory Committee on Immunization Practices [ACIP]. MMWR 1999:48[No. RR-12]:1-37)

and includes (1) new data on the epidemiology of hepatitis A in the era of hepatitis A vaccination of children in selected U.S. areas, (2) results of analyses of the economics of nationwide routine vaccination of children, and (3) recommendations for the routine vaccination of children in the United States. Previous recommendations for vaccination of persons in groups at increased risk for hepatitis A or its adverse consequences and recommendations regarding the use of immune globulin for protection against hepatitis A are unchanged from the 1999 recommendations.

To access a ready-to-print (PDF) version of this issue of “Prevention of Hepatitis A Through Active or Passive Immunization: Recommendations of the Advisory Committee on Immunization Practices (ACIP)" in MMWR Recommendations and Reports go to: www.cdc.gov/mmwr/PDF/rr/rr5507.pdf
To access a web-text (HTML) version, go to:
www.cdc.gov/mmwr/preview/mmwrhtml/rr5507a1.htm

Hepatitis B

The CDC now recommends that all newborns receive a birth dose of hepatitis B vaccine before leaving the hospital *unless* a physician provides a written order to defer the birth dose. CDC also recommends that all children age 19 and younger receive the vaccine series.

Delay in 'rare circumstances'

"On a case-by-case basis and only in rare circumstances," the birth dose may be delayed until after hospital discharge, according to the new recommendation. This exception applies only to infants who weigh at least 2,000 grams and whose mothers are known to be HBsAg negative during the current pregnancy. When a decision is made to delay the birth dose, a physician's order to withhold the birth dose and a copy of the original laboratory report indicating that the mother was HBsAg negative during this pregnancy must be placed in the infant's medical record.

In infants who do not receive a first dose before hospital discharge, the first dose should be administered no later than 2 months of age.

CDC recommendations also state that the birth dose should not be delayed if the infant's mother engaged in high-risk sexual or drug-using practices during pregnancy (e.g., having had more than one sex partner during the previous six months or an HBsAg-positive sex partner, evaluation or treatment for an STD, or recent or current injection-drug use) or in situations of expected poor compliance with follow-up to initiate the vaccine series. Preterm infants weighing less than 2,000 grams and born to HBsAg-negative mothers should have their first vaccine dose delayed until one month after birth or hospital discharge, whichever comes first. For these infants, a copy of the original laboratory report indicating that the mother was HBsAg negative during this pregnancy should be placed in the infant's

medical record. The recommendations call for physician follow-up in infants whose birth dose is delayed.

Catch-up

Hepatitis B vaccination is recommended for all children and adolescents 19 years of age and under. Children and adolescents who have not previously received hepatitis B vaccine should be vaccinated routinely at any age with an appropriate dose and schedule, but all children aged 11-12 years should have a review of their immunization records and should complete the vaccine series if they were not previously vaccinated or were incompletely vaccinated. If a child has an incomplete vaccination history for hepatitis B there is never a recommendation to restart the series. As long as the minimum interval between doses has been met, subsequent dose(s) can be administered to complete the series.

[The CDC recommendation is online at www.cdc.gov/mmwr/PDF/rr/rr5416.pdf or see the Dec. 23, 2005, Morbidity and Mortality Weekly Report (MMWR. 2005;54(RR-16):1-23)].

If you prefer a web-text (HTML) version of the ACIP recommendations, use the following links:

For the main text of the ACIP recommendations, go to:
ww.cdc.gov/mmwr/preview/mmwrhtml/rr5416a1.htm

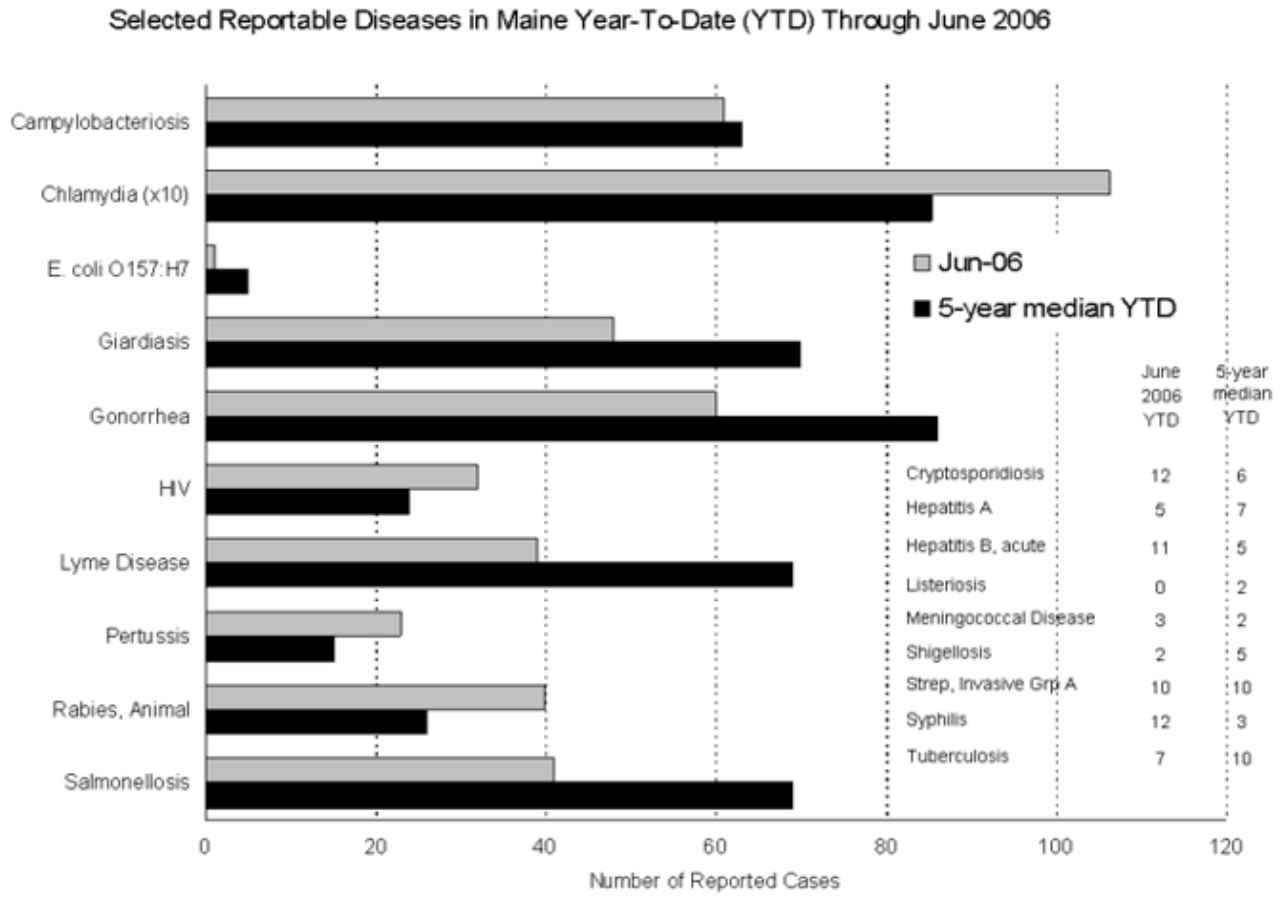
For Appendix A (Case finding and management of hepatitis B surface antigen [HBsAg]—positive persons during delivery of vaccination services), go to:
www.cdc.gov/mmwr/preview/mmwrhtml/rr5416a2.htm

For Appendix B (Immunization management issues), go to:
www.cdc.gov/mmwr/preview/mmwrhtml/rr5416a3.htm

For Appendix C (Postexposure prophylaxis of persons with discrete identifiable exposure to hepatitis B virus [HBV]), go to:
www.cdc.gov/mmwr/preview/mmwrhtml/rr5416a4.htm

Contributed by Mary Kate Appicelli

Selected Reportable Diseases in Maine Year-to-Date (YTD) Through June 2006



Note: Data are preliminary as of 7/17/06.

Contributed by Andrew Pelletier

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Please call Maine CDC to report all reportable diseases:

Telephone Disease Reporting Line:
24 hours / 7 days
1 800 821-5821

Consultation and Inquiries:
24 hours / 7 days
1 800 821-5821

Facsimile Disease Reporting Line:
24 hours / 7 days
1 800 293-7534

Department of Health and Human Services
Maine Center for Disease Control and Prevention
(Formerly Bureau of Health)
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11 State House Station
Augusta, ME 04333-0011